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June 4, 2001

To: All Community Based Alternatives (CBA) Home and
Community Support Services (HCSS) Providers

Subject: Long Term Care (LTC)
Information Letter No. 01-05
New Service Codes

This letter provides additional information regarding the new LTC Service Codes provided with CMS Information Letter No. 2001-04. HCSS agencies must ensure that these new services codes are implemented with claims submitted for services provided on or after September 1, 2001.

REVISED INDIVIDUAL SERVICE PLAN (ISP)

CBA case managers will begin using the attached Form 3671-1 Individual Service Plan (ISP), page 1 for all new authorizations or reassessment authorizations with a September 1, 2001 effective date. The revised ISP form now includes separate service codes for Requisition Fees and Specifications.

REVISED NURSING SERVICE PLAN

The attached CBA Nursing Service Plan Form 3671-C must be used to request nursing services for ISP's with an effective date on or after September 1, 2001. Section II. Nursing Tasks, Item 16 has been revised to allow the HCSS agency to separately identify the hours requested for specifications and orientation.

REVISED THERAPY SERVICE AUTHORIZATION

The attached CBA Therapy Service Authorization Form 3671-B must be used to request therapy services for ISP's with an effective date on or after September 1, 2001. Item 45 of this form has been revised to allow the HCSS agency to separately identify hours requested for specifications and orientation.

REVISED SERVICE DELIVERY RECORD

Beginning September 1, 2001, HCSS agencies must ensure that the attached Documentation of Services Delivered Form 3670 is used. The form has been revised to include new service codes 41-C Specifications-Adaptive Aids and 41-D Specifications-Minor Home Modifications which replace the current Specifications Code 40. The HCSS providers who are currently using a DHS approved substitute Form 3670 may incorporate the new codes without requesting DHS approval.

BILLING

HCSS agencies must ensure that adaptive aid specifications drawn up by a nurse or therapist are billed using the new service code 41-C Specification-Adaptive Aids and billing code G0607. For example, if one hour of nursing is requested for specifications on Form 3671-C Nursing Service Plan, the HCSS agency must ensure that \$40.70 (1 hr. of Nursing) is claimed with Service Code 41-C on the Documentation of Services Delivered Form 3670. The HCSS agency must also ensure that claims for Minor Home Modifications specifications are submitted using Service Code 41-D Specifications-Minor Home Modifications and billing code G0604.

The new service codes for Requisition Fees are 41 Adaptive Aids , 41-A Medical Supplies and 41-B Minor Home Modifications.

If you have any questions about this information please contact your contract manager.

Sincerely,
signature on file

Becky Beechinor
Assistant Deputy Commissioner
Long Term Care Services

BB:ck

Attachments

COMMUNITY BASED ALTERNATIVES
DOCUMENTATION OF SERVICES DELIVERED

SECTION A—PARTICIPANT INFORMATION

1. Name	2. Service Month and Year
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SECTION B—SERVICES

3. Program Provider Name	4. Vendor No.
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5. Method of Delivery (check only one)

☐ Employee—Name of this Employee/Subcontractor: _____

☐ Personal Service Agreement—Name of Individual: _____

☐ Direct Purchase (use with service 15, 16, or 22 only)

6. Authorized Service (check only one)

<input type="checkbox"/> 7—Occupational Therapy	<input type="checkbox"/> 13—Nursing Service	<input type="checkbox"/> 22—Medical Supplies
<input type="checkbox"/> 8—Physical Therapy	<input type="checkbox"/> 15—Adaptive Aids	<input type="checkbox"/> 40—Reassessment
<input type="checkbox"/> 9—Speech Pathology	<input type="checkbox"/> 16—Minor Home Modifications	<input type="checkbox"/> 41-C—Specifications - Adaptive Aids
<input type="checkbox"/> 11—Respite Care, In Home	<input type="checkbox"/> 17—Personal Assistance	<input type="checkbox"/> 41-D—Specifications - Minor Home Modifications

Comments:

SECTION C—RECORD OF TIME

UNIT OF SERVICE:

☐

Hours

☐

Days

☐

N/A

DAY	UNITS	DAY	UNITS	DAY	UNITS	DAY	UNITS	DAY	UNITS	DAY	UNITS	DAY	UNITS	DAY	UNITS
1		5		9		13		17		21		25		29	
2		6		10		14		18		22		26		30	
3		7		11		15		19		23		27		31	
4		8		12		16		20		24		28			
												TOTAL UNITS:			

SECTION D—CERTIFICATIONS

This is to certify that I, the timekeeper, have verified that the units of service were delivered as documented.

This is to certify that I, the employee, provided the services recorded above, or that I completed all work required according to all specifications.

Signature—Timekeeper

Date

Signature—Employee

Total Units - This item represents the sum of all units recorded in the record of time. It should be rounded to the nearest 1/4 unit. Time in hours and minutes must be converted to the decimal equivalent in hours.

Example: 1 hour 30 minutes = 1.5 hours:

If more than one individual provides a single category of service (for example, several attendants serve the same client), a separate Form 3670 must be completed by each individual provider. In this case, add all actual hours of service delivered by each individual provider; round the total up to the next 1/4 unit; convert to the decimal equivalent in hours; and bill for that amount.

Service Codes 1 5, 1 6, and 22 - Instead of the time, enter the dollar amount of the service provided. If there is an inspection fee for the minor home modification, also enter the dollar amount of the fee. **Note:** Enter the cost of the inspection separately from the cost of the modification.

Service Code 40 - Enter a "1" if it is a reassessment on the date the reassessment was done.

Service Codes 41-C and 41-D - Enter the dollar amount on the date the Adaptive Aid specifications were developed. For Minor Home Modifications, enter the dollar amount on the date of signature on Form 3849.

SECTION D - CERTIFICATION

For Service Codes 7 through 9, 19, 13, 40, and 17 -the HCSS agency employee performing the service must sign the Form 3670 to certify that services were delivered.

An employee who is unable to complete Form 3670 may designate a neighbor, friend, or relative to complete and sign the form. There must be written documentation of the reason why the attendant is unable to complete and sign the timesheet and of the person authorized **to make the entries for the employee.**

A timekeeper must be designated to verify that the units of service recorded on the form were delivered as authorized on the participant's Individual Service Plan

(ISP). The timekeeper may be the supervisor or other designated person.

The timekeeper must sign and date the form on or after the last workday of the pay period. If a signature stamp is used, the timekeeper must initial the stamped signature. Enter the month, day, and year the form is signed.

For Service Codes 75, 16,22,40,41C, and 41D

Specification - a representative of the HCSS agency must sign Form 3670 to certify that items were purchased and delivered as authorized, or specifications or annual reassessment done.

Copies of the invoices or receipts for the purchases must be attached to the Form 3670.

Services billed to DHS without a completed and signed Form 3670 are subject to recoupment.

Note: Form 3670 must not be pre-signed or predated.

CORRECTIONS TO ENTRIES

Method of Correction - To correct an error, line through the error, write the correct entry, and initial the correction. Do not use liquid paper/ correction fluid. Original entries, corrections, and initials must be legible.

Identifying Information - The timekeeper must initial the correction.

Record of Time -

- The employee must initial each correction that increases the number of hours worked each day.
- The timekeeper may reduce or delete the number of hours recorded for a day if the reduction or deletion is caused by the employee's absence from work or an interruption of services.

COMMUNITY BASED ALTERNATIVES – INDIVIDUAL SERVICE PLAN

1. Group Code	2. Medicaid No.	3. Participant Name-Last, First, MI			4. BJN	
5. Effective Date	6. ISP Dates From: To:		7. Date of Birth (MM/DD/YYYY)	8. Social Security No.	9. County	10. Region
11. Type Authorization <input type="checkbox"/> Initial (new) <input type="checkbox"/> ISP Change <input type="checkbox"/> Reassessment <input type="checkbox"/> Termination <input type="checkbox"/> Provider Change					12. Reason If Terminated	
13. Enrolled From <input type="checkbox"/> 1-Hospital <input type="checkbox"/> 2-Nursing Facility <input type="checkbox"/> 5-Home			14. Living Arrangement after Entry into CBA <input type="checkbox"/> 1-Alone <input type="checkbox"/> 2-With Other Waiver Participants <input type="checkbox"/> 3-AL/RC <input type="checkbox"/> 4-AFC <input type="checkbox"/> 5-With Family			15. TILE

16. SERVICE CATEGORY	17. VENDOR ID NO.	18. EST. ANNUAL SERVICE UNITS	19. UNIT RATE	20. ESTIMATED ANNUAL COST
<input type="checkbox"/> 17–Personal Assistance Services (PAS)				
<input type="checkbox"/> 8–Physical Therapy				
<input type="checkbox"/> 7–Occupational Therapy				
<input type="checkbox"/> 9–Speech Therapy				
<input type="checkbox"/> 13–Nursing Services				
<input type="checkbox"/> 22–Medical Supplies		DO NOT WRITE IN THIS SPACE		
<input type="checkbox"/> 15–Adaptive Aids		DO NOT WRITE IN THIS SPACE		
<input type="checkbox"/> 16–Minor Home Modifications		DO NOT WRITE IN THIS SPACE		
<input type="checkbox"/> 40–Assessment/Annual		DO NOT WRITE IN THIS SPACE		
<input type="checkbox"/> 41–Requisition Fees–Adaptive Aids				
<input type="checkbox"/> 41A–Requisition Fees–Medical Supplies				
<input type="checkbox"/> 41B–Requisition Fees– Minor Home Modifications				
<input type="checkbox"/> 41C–Specifications– Adaptive Aids				
<input type="checkbox"/> 41D–Specifications–Minor Home Modifications				
<input type="checkbox"/> 11–Respite–In-Home				
<input type="checkbox"/> 11B–Respite–Foster Care				
<input type="checkbox"/> 11C–Respite–Assisted Living Apartment				
<input type="checkbox"/> 11D–Respite–AL/RC Apartment				
<input type="checkbox"/> 11E–Respite–AL/RC Non-apartment				
<input type="checkbox"/> 11F–Respite–Nursing Facility				
<input type="checkbox"/> 20–Emergency Response Services				
<input type="checkbox"/> 19–Assisted Living–Apartment				
<input type="checkbox"/> 19A–Assisted Living–RC Apartment				
<input type="checkbox"/> 19B–Assisted Living–RC Non-apartment				
<input type="checkbox"/> 19C–Assisted Living–Personal Care 3				
<input type="checkbox"/> 19D–Assisted Living–Emergency Care				
<input type="checkbox"/> 18–Adult Foster Care–Level 1				
<input type="checkbox"/> 18–Adult Foster Care–Level 2				
<input type="checkbox"/> 18–Adult Foster Care–Level 3				
<input type="checkbox"/> 25–Meals				
<input type="checkbox"/> Conavment-Initial	(Initial Month)•	\$	DO NOT WRITE IN THIS SPACE	
<input type="checkbox"/> Conavment-Ongoing	(Monthly)•	\$	DO NOT WRITE IN THIS SPACE	
Worker Name		Annual Cost Ceiling		Subtotal
		\$		\$
Office Name and Mail Code		Ventilator Use		Total Est. Part. Copay
		<input type="checkbox"/> 6 - 23 Hours <input type="checkbox"/> 24 Hours		– \$
				Total Est. Waiver Costs
				= \$

Items 12/24/36 Assessment - Total Hours Approved - (B). The case manager enters "4" as the therapy hours for the initial assessment. This initial authorization includes time allowed for the initial therapy session. If third party resources (TPR) can be accessed to provide for the therapy, the case manager enters "0" here. This is also added into the total hours authorized, items 18,30 and 42 by the case manager before transferring to Form 3671, page 1, in the appropriate service category.

Items 13/25/37 Date Direct Services Initiated - (D). Enter the date therapist initiates direct service plan, the same date as the therapist's signature on the form. If the therapist's assessment determines that therapy is not recommended, the therapist will put "n/a" in this space and provide an explanation in item 44 or on additional page as to why therapy not initiated.

Items 94/26/38 Number of Days per Week (D). The therapist enters the number of days per week therapy is to be scheduled.

Items 1 5/2 7/39 Number of Hours per Visit (D). The therapist enters the number of hours per visit.

Items 16/28/40 Total Hours per Week - (D). The therapist enters the total number of hours therapy will be performed per week.

Items 17/29/41 Stop Date (or duration) - (D). The therapist enters the date therapy is due to stop, or if that is not known, enter the scheduled duration (i.e., three weeks, six weeks, two months, etc.).

Items 18/30/42 Total Hours Authorized - (B). The case manager enters the total hours authorized for the duration of the therapy after the HCSS agency returns Form 3671-B with the therapist's proposed service, plan. The case manager obtains this total by multiplying the total hours/week in items 16, 28; or 40 by the weeks specified in items 17, 29, or 41. The case manager also adds in hours used for assessment (items 12,24, and 36) and adds in hours used for developing specifications and providing orientation/training as indicated in item 45. This information is entered in 18, 30, or 42 and transferred to the ISP, Form 367 1, page 1, by the case manager in the items related to the specific therapy authorized.

Items 19/31/43 CBA/TPR - (A). The HCSS RN indicates whether the therapy is being provided through the CBA program or by Third Party Resources. If provided by TPR it will be listed on Form 3671, page 3. If the therapy being provided by TPR appears to be meeting the needs of the participant, then therapy from CBA is not authorized.

Item 44. Description of Direct Services - (D). The therapist completes this section upon formulating a treatment plan for the participant. Additional pages may be used, if needed. Following the assessment, if no therapy is indicated, the therapist will provide an explanation in this section.

Item 45. - (D). Enter the number of hours required to develop specifications or provide orientation as documented by HCSS agency staff on Form 3848. Also indicate the type of therapist provider by checking the appropriate box. For specifications hours, the case manager should convert the number of hours to a dollar amount and transfer this amount to Form 367 1-1, Item 41-C, Column 20. The case manager should include the orientation hours in item 1 8, total hours authorized including assessment and orientation.

COMMUNITY BASED ALTERNATIVES
NURSING SERVICE PLAN

1. Applicant/Participant Name	2. Medicaid No.	(THIS SPACE FOR DHS USE ONLY) 3. Effective Date
4. Case Manager		5. Provider Vendor No.

I. GRAND TOTALS (Section I for DHS use only)

A. PAS Hours (Delegated Nursing Hours)	B. Direct Nursing Hours	C. Number of Program Required Direct Nursing Hours
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II. NURSING TASKS

A. NURSING TASKS	B. AFC LEVEL	C. HOURS PER MONTH AS NEEDED	D. HOURS DELEGATED TO PAS OR AFC PROVIDER	E. HOURS PERFORMED BY INFORMAL SUPPORT	F. HOURS PERFORMED BY MEDICARE/ OTHER	G. DIRECT NURSING PERF. BY HCSS PROVIDER
1. Administration of oral medications or administration of medications through permanently placed feeding tubes, SL, or topically.	II					
2. Feeding through permanently placed gastrostomy tube.	II					
3. Sterile procedures.	II					
4. Non-sterile procedures.	I/II					
5. Invasive procedures.	II					
6. Care of broken skin involving a wound other than minor abrasions or cuts.	II					
7. Elimination.	II					
8. Collecting, reporting, and documenting data.	I					
9. Reinforcement of health teaching planned and/or provided by RN.	I					
10. Ambulation, positioning, turning.	II					
11. Other (specify):						
12. TOTALS						

(THIS BLOCK FOR DHS USE ONLY)

13. Number of months remaining in current ISP year. x

(THIS BLOCK FOR DHS USE ONLY)

14. Subtotal =

15. For ISP changes, enter the number of Section II nursing hours already authorized from start of current ISP year through date of request for change. +

16. Number of nursing hours needed to develop specifications.

17. Number of nursing hours needed to provide orientation. +

18. Direct nursing hours by HCSS nurse needed this ISP year. =
(THIS BLOCK FOR DHS USE ONLY)(Convert hours to a dollar amount and transfer to
Form 3671-1, Item 41-C, Column 20.)**III. NURSING SERVICES RELATED TO DELEGATION/TRAINING**

A. DELEGATION/TRAINING ACTIVITIES	B. TOTAL ANNUAL HOURS NEEDED FOR EACH ACTIVITY
1. Initial Delegation Activities	
2. Ongoing Delegation Activities	
3. Training of Family Members/Informal Support Providers	
4. TOTAL ANNUAL HOURS REQUESTED FOR DELEGATION/TRAINING ACTIVITIES	

IV. MANDATORY DIRECT NURSING SERVICES TO BE AUTHORIZED (Section IV for DHS use only)

A. HOURS TO BE AUTHORIZED BY PROGRAM REQUIREMENTS		B. NUMBER OF HOURS AUTHORIZED
1. Ten hours to allow direct nursing provision to prevent service breaks for participants in their own homes who have delegated nursing tasks.		
2. Four hours for the HCSS nurse to decide if tasks will be delegated to the AFC Level I or II provider.		
3. Three hours for crisis intervention for all waiver participants except those in AFC homes run by nurses.		
4. Eight hours annually for the Quarterly Nursing Assessment/MDS for all waiver participants.		
5. TOTAL NUMBER OF HOURS AUTHORIZED FOR PROGRAM REQUIREMENTS		

V. RECOMMENDATIONS

1. Can applicant/participant be left unsupervised for up to three hours at a time? <input type="checkbox"/> Yes <input type="checkbox"/> No	2. RN's Recommendation for AFC Level: <input type="checkbox"/> Level I <input type="checkbox"/> Level II <input type="checkbox"/> Level III
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VI. OPTIONAL WEEKLY SCHEDULES -- Initial Weekly Schedule for Nursing Visits (See 2060-A for PAS schedule.)

TOTAL VISITS/HOURS	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

Comments:

Ongoing Weekly Schedule for Nursing Visits (To be completed only if there is an anticipated schedule change.)

TOTAL VISITS/HOURS	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

Comments:

Ongoing Weekly Schedule for Nursing Visits (To be completed only if there is an anticipated schedule change.)

TOTAL VISITS/HOURS	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

Comments:

CERTIFICATION BY INTERDISCIPLINARY TEAM MEMBERS: The waiver services identified above for this applicant/participant are necessary to prevent nursing facility placement and are appropriate to meet the needs of the applicant/participant in the community.

Signature—HCSS Nurse Assessor	Date	Signature—Applicant/Participant/Resp. Party	Date
Signature—Case Manager	Date	Signature—HCSS Representative (if required)	Date
Signature—Informal Support (if required)	Date	<input type="checkbox"/> Signatures on Form 3671, Page 2	

CBA INDIVIDUAL SERVICE PLAN - NURSING SERVICE PLAN

PURPOSE

This form is completed by the HCSS agency nurse to:

- provide a worksheet for the initial development of the Individual Service Plan;
- identify nursing tasks to be delegated, directly provided or provided through Medicare, other third party resources, family and other informal support;
- project hours per month required to perform nursing tasks, including delegated nursing tasks;
- request delegation and training hours; and
- provide the CBA case manager a recommendation on:
 - if the participant can be left unsupervised for up to three hours at a time.
 - the level of Adult Foster Home placement.

This form is used by the case manager to:

- determine the level of the AFC home appropriate for the applicant based on the nurse's recommendation; and
- approve the nursing service plan prepared by the Home and Community Support Services (HCSS) agency.

PROCEDURE

When to Prepare

The HCSS agency RN completes the items on the form based on the instructions below but may not complete any of the items marked "For DHS Use Only." The items to be completed by the RN were shaded in earlier versions of this form.

The HCSS nurse completes:

- (1) Items 1, 2, 4, and 5 in the identifying data at the top of page 1;
- (2) Section II: C, D, E, F, G for items 1-12 and item 15 and 16;

- (3) Section III: B. 1-4;
- (4) Section V: 1 and 2;
- (5) Optional schedule for Nursing Visits, page 2; and
- (6) Signatures, date, in Certification by Interdisciplinary Team Members, page 2;
 - when completing the pre-enrollment home health assessment,
 - when requesting service plan changes during the ISP year or at the time of the coordination of the initial ISP, or
 - when performing the assessment for the annual service plan revision.

The case manager completes the following:

- (1) 3, ISP Date in the identifying information section;
- (2) Section I: A, B, C;
- (3) Section 11, 13, 14 and 18;
- (4) Section IV: B 1-5;
- (5) Signature, date, page 2;
 - When approving the services identified on Form 3671-C completed as part of the pre-enrollment home health assessment;
 - when approving service plan changes from the HCSS agency; and
 - when approving the services identified on the form following the annual re-assessment

Number of Copies

An original form for the case manager and a copy for:

- (1) the authorized HCSS, AFC, and AL/RC provider agency(ies); and
- (2) each member of the Interdisciplinary Team (IDT).

Transmittal

The original 3671-C is submitted to the case manager by the HCSS nurse:

- after completion of the pre-enrollment home health assessment, within the time frame indicated on Form 3676;
- within two DHS workdays after negotiating for a change in initial service plan at the time of the coordination of the initial ISP;
- within seven days when requesting emergency and routine service plan changes;
- after completion of the annual reassessment.

With each form revision, the case manager maintains the original in the participant's case folder and mails or gives copies to the authorized HCSS agency, AL/RC facility, AFC home, and IDT members within 14 days of receipt of the notification of the need for a service plan change which is approved.

The case manager sends a copy of this form to the receiving HCSS agency when there is a HCSS agency provider change to inform the receiving agency of the ISP and to obtain a signature from a representative of the HCSS agency to acknowledge his agreement with the services identified on this form.

Form Retention

Each provider must keep copies of Form 3671-C in the participant's case record according to the retention requirements found in the *Community Based Alternative Program Provider Manual*. The case manager will keep all originals to this form in the participant's folder for five years after services are terminated.

Supply Source

This form may be photocopied from the *CBA Provider Manual*.

DETAILED INSTRUCTIONS

Identifying data

- 1. Applicant/Participant Name** –Self explanatory.
- 2. Medicaid Number** - Enter the applicant/ participant's nine-digit Medicaid number.
- 3. Effective Date** - Enter the Effective Date from the ISP, Form 3671, page 1, of the initial ISP, reassessment ISP, or ISP change that includes the authorization for the nursing services contained on this Form 3671-C.
- 4. Case Manager** - Enter the name of the CBA case manager for the applicant/participant.
- 5. Provider Vendor No.** - Enter the CBA vendor number for the HCSS agency.

I. Grand Totals

- PAS Hours** - (Delegated nursing tasks) Enter total hours identified in Section II, # 12, column D to be done by the PAS attendant. This must be included on Form 2060-A when calculating PAS hours also.
- Direct Nursing Hours** - Enter total hours needed for direct delivery, delegation, training and program required hours for licensed nurses as identified in:
 - Section II, # 18, hours of nursing tasks needed current year; plus
 - Section III, #4, total of column B; plus
 - Section IV, #5, total of column B.
- Number of Program Required Direct Nursing Hours** - Enter the total of program required direct nursing hours as identified in Section IV, #5, total of column B.

The total of B should include any nursing hours already authorized and delivered in the current ISP period and is the number of units of nursing authorized in the estimated annual units column on Form 3671, page 1, Nursing Services.

II. Nursing Tasks

Check any of the tasks the applicant/participant requires as identified in 1-11.

Identify-the need for the tasks based on the data as assessed on Form 3652, CARE, from what the applicant/participant says, documentation in the clinical record, any physician's orders and nursing judgement. Identify the needed task(s) as a task that is needed even if it is currently being provided by other resources, i.e., attendants, AFC providers, family, friends (informal support), Medicare, and other third party resources.

Tasks 9-10 - Specific nursing tasks. These nursing tasks may be delegated according to the rules from the Board of Nurse Examiners for the State of Texas, 22 TAC §218.

Personal assistance services such as bathing, toileting, walking, and other activities of daily living (ADLs) will be identified by the case manager on Forms 2060 and 2060-A. Tasks identified on Form 2060-A as a personal assistance service must not also be identified as a delegated task. The nurse and the case manager may need to collaborate in assessing this aspect of care.

For applicant/participants living in AFC homes run by licensed nurses; the HCSS nurse will identify the tasks only by checking the appropriate task(s) 1-11.

Task 11 - This task will be identified if there is a task, other than the tasks listed above in 1-10, which would be non-delegable to an unlicensed person and must be provided directly by a licensed nurse or trained family members or informal support such as I.M. injections or insulin injections. Note: The exception is when using to document the need for extension of therapy.

12. Totals - Enter the totals for columns C-G.

13. Number of months remaining in current ISP year - Enter the number of months remaining in the ISP. Use 12 for initial and reassessment ISPs, round fractions to the next higher month. .

14. Subtotal - Multiply the total in 12. G by the number of months remaining in the ISP effective period entered in item 13 and enter the number as the subtotal for nursing tasks.

15. Number of Nursing Hours Already Authorized - For ISP changes, enter the number of direct nursing hours for nursing tasks in Section 11. authorized and scheduled to have been provided already in the current ISP. Enter the estimated units, or the units actually delivered, if known, up until the effective date of the ISP change.

16. Number of hours needed to develop specifications - Enter hours as documented on Form 3848. The case manager should convert the hours recorded in this item to a dollar amount and transfer to Form 3671-1, Item 41-C, Column 20.

17. Number of hours needed to provide orientation - Enter hours as documented on Form 3848.

18. Number of direct nursing hours by HCSS nurse needed this ISP year - Enter the sum of items 14, 15, and 17.

EXPLANATION OF COLUMNS IN IL NURSING TASKS

B. AFC Level - With each identified task, there is an associated level of AFC home in which the task may be provided. The nurse must be knowledgeable of the task (s) which can be provided in different levels of AFC homes in order to make a recommendation for AFC level placement. Based on the identified tasks and associated AFC level as printed beside the tasks, the nurse makes a recommendation for AFC placement in Section V.2 of this form.

C. Hours per month needed - Enter the hours needed per month to perform the identified task as performed by one or more providers.

Enter the number of hours needed in whole units. (Hours entered in columns D-G of an identified task will add up to the number entered in column C of an identified task.)

In determining the hours per month needed on a task, the nurse uses her professional judgment and experience in entering the hours needed per month to provide the identified task for the participant.

In calculating the nursing hours, the nurse must project a one hour minimum per visit and round up to the nearest quarter hour in decimals if nursing hours are greater than one hour.

Not applicable for participants living in AL/RC facilities needing administration of medications. This task is provided by the facility. The task will be identified, if applicable, but no hours calculated.

Not applicable for those participants residing in AFC Level III homes or in any other level AFC home run by a licensed nurse.

D. Hours Delegated to PAS or AFC Provider -The nurse will identify the unlicensed person receiving delegation by circling the PAS or the AFC Provider.

Enter the total monthly number of hours needed to perform each nursing task. Enter the number of hours needed in whole units. Add up the hours required for each task and enter in column D, line 12.

(This number will be a part of or the same number of hours needed per month as identified in column C.) .

There is no delegation in AL/RC facilities.

Families and informal support cannot be delegated to but they can receive training from the licensed nurse to perform the identified tasks. Nursing task hours performed

by families and informal support will be entered in column E.

If delegation is to the personal care attendant, the case manager converts the monthly number of hours to weekly by dividing by 4.33 and enters this weekly total in item II. 3. A. of Form 2060-A

E. Hours Performed by Informal Support - Enter the number of nursing hours for each identified task that will be provided monthly by non-paid informal support to include family and friends. (This number will be a portion or all of the total hours needed per month as identified in column C.)

F. Hours Performed by Medicare/Other -

Enter the monthly hours that Medicare and other third party resources, excluding family and informal supports, are providing of an identified task.

- If the task is being totally provided by a TPR, do not enter the number of required hours to perform the task but identify that the task is being provided by a TPR by entering a check mark.
- If the performance of the task will be provided by a TPR and the CBA program, enter the number of hours that the other resource will be providing. (This number will be a portion of the total hours needed per month as identified in column C.)

G. Direct Nursing by HCSS Provider - Enter the number of monthly hours the licensed nurse will need to provide the identified task on a monthly basis.

If the nurse will be sharing a task with other providers, i.e.; as identified in columns D, E, and/or F, the total of all identified columns must add up to the total of hours entered in column C for the identified task.